Summary of Coverage

Employer: Fairfax County Public Schools

ASC: 724425

SOC: 1A

Issue Date: October 16, 2002

Effective Date: January 1, 2002

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time employee of an employer participating in this Plan and have elected coverage under the Exclusive Provider Organization (EPO) plan which includes Special Comprehensive Medical Expense Coverage.

Your Eligibility Date is the first day of the calendar month coinciding with or next following the date you commence active work for your Employer, but not before the later of the Effective Date of this Plan and the date you enter the Eligible Class.

Dependents

You may cover your:

- wife or husband; and
- unmarried children who are under 19years of age.

Any other unmarried child under age 23 who goes to school on a regular basis and depends solely on you for support will be covered as a dependent.

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren.
- Any other child you support who lives with you in a parent-child relationship.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

You will get a form to fill out. This form will allow your Employer to deduct your contributions from your pay. Be sure to sign and return it within 31 days of your eligibility.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details.

Effective Date of Coverage

Employees

Your coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date you return your signed form.

If you don't sign and return your form within 31 days of your Eligibility Date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions. If you do not do so within 31 days of any dependent's eligibility date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the January 1st following the end of the annual enrollment period during which you elect coverage for the Late Enrollee.

Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:

  the person was covered under other "creditable coverage" as defined below; and

  you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:

  of termination of employment in a class eligible for such coverage;

of reduction in hours of employment;

your spouse dies;

you and your spouse divorce or are legally separated;

such coverage was COBRA continuation and such continuation was exhausted; or

the other plan terminates due to the employer's failure to pay the premium or for any other reason; and

- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election.

Additional Exceptions

Also, a person will not be considered a Late Enrollee if you did not elect, when the person was first eligible, Health Expense Coverage for:

- A spouse or child who meets the definition of a dependent, but you elect it later and within 31 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through marriage, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the election.
- Yourself and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.
- Yourself and your spouse and you subsequently acquire a dependent, who meets the definition of a dependent, through birth, adoption, or placement for adoption, and you subsequently elect coverage for yourself, your spouse, and any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective; provided you make written request for such coverage within 31 days of the court order. Coverage for the child will become effective on the date of such court order. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Prescription Drug Expense Coverage

Payment Percentage
100% after a 20% copayment. The copayment is not to be less then the minimums or more then the maximums listed below:

Retail Preferred and Non-Preferred Pharmacies for a Supply of up to 34 days	Per Prescription or Refill	
	Minimum	Maximum
Brand Name Drugs	$ 15	$ 25
Generic Drugs	$ 7	$ 25

Payment Percentage
100% after a 20% copayment. The copayment is not to be less then the minimums or more then the maximums listed below:

Preferred Mail Order Pharmacy for a Supply of over 34 days*	Per Prescription or Refill	
	Minimum	Maximum
Brand Name Drugs	$ 30	$ 50
Generic Drugs	$ 14	$ 50

* but no more than a 90 day maximum supply.

Special Comprehensive Medical Expense Coverage

Certain health care providers have agreed to provide their services or supplies at a "negotiated charge". They are called "Preferred Care Providers". See your Employer for a list of these health care providers or visit Aetna's website at www.aetnaushc.com.

Your Primary Care Physician coordinates your medical care, except care for the effective treatment of alcoholism or drug abuse or for the treatment of a mental disorder. The Behavioral Health Care Coordinator (BHCC) coordinates your medical care for the effective treatment of alcoholism or drug abuse and for the treatment of a mental disorder.

You must contact:

- The BHCC at the number shown on your ID card, before you receive any care for the effective treatment of alcoholism or drug abuse or for the treatment of a mental disorder. Contact with the BHCC may take place after medical care is given to treat an "emergency condition", as defined in your Booklet. You must make this contact as soon as possible after the initial treatment.
- Your Primary Care Physician before you receive any medical care which he or she coordinates.

BENEFIT LIMITATIONS:

As to care for the effective treatment of alcoholism or drug abuse or for the treatment of a mental disorder, care must be recommended and approved by the BHCC and you must follow the treatment which is recommended and approved by the BHCC in order for benefits to be payable under this Plan for Covered Medical Expenses incurred for such care.

As to all other care, benefits will only be payable under this Plan for Covered Medical Expenses incurred for medical care provided by:

- a person's Primary Care Physician or a Preferred Care Provider upon referral of the Primary Care Physician;
- a Non-Preferred Care Provider on the referral of the person's Primary Care Physician and if approved by Aetna; or
- any health care provider for an "emergency condition", as defined in your Booklet, when travel to a Preferred Care Provider is not feasible.

Note: If a contract with a Preferred Care Provider is terminated, benefits for the Covered Medical Expenses incurred by a person during a course of treatment in progress at the time of such termination will continue to be provided until the earliest of:

- the date such course of treatment is completed;
- the date reasonable and appropriate arrangements are made for the assumption of such course of treatment by another health care provider; or
- the date the person's coverage under this Plan terminates.

Exceptions:

Expenses incurred for the following services furnished by a Preferred Care Provider will be payable at the preferred level of benefits without referral by your Primary Care Physician if they are considered Covered Medical Expenses of this Plan:

One routine eye exam in 24 consecutive months;

Obstetrical and gynecological services (i.e., the types of services appropriately provided by, or under the direction of, an obstetrician or a gynecologist); and

A mammogram in accordance with the guidelines described in your Booklet; and

Other services, if identified in your Provider Directory as being available without his or her referral.

Annual Gynecological Exam

Expenses incurred for one routine gynecological exam given by a Preferred Care Provider without referral by your Primary Care Physician will be considered a Covered Medical Expense. Charges for one self-referred exam per calendar year will be paid at the preferred level of benefits. Any subsequent visits or treatment must be on referral by your Primary Care Physician in order for the preferred level of benefits to apply to that care. The routine gynecological exam is considered Office Care. No coverage is provided if the exam is given by a Non-Preferred Care Provider.

Healthy Outlook Program

This is a disease management program for covered persons with one or more of the following chronic conditions:

- asthma;
- congestive heart failure;
- diabetes; and
- low back pain.

A "participant" in this program is a covered person:

- who has identified himself or herself; or
- who has been identified by:
  his or her attending physician or other health care provider; or
  Aetna; or
  his or her Employer; and
- who is approved by Aetna as a participant.

Covered Medical Expenses incurred by a participant for services authorized by Aetna under the Healthy Outlook Program will be paid at 100%. Any applicable copay must be paid by the participant. Any applicable deductible will be waived.

Any visit or day calendar year maximum or visit or day lifetime maximum under this Plan will not be reduced. However, any dollar calendar year maximum or dollar lifetime maximum under this Plan will be reduced.

Emergency Room Copay $ 35

This Emergency Room Copay applies to Hospital Expenses incurred for emergency care provided by a Preferred Care Provider.

The Benefits Payable

After any copay amount, the Health Expense Benefits paid under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet.

If any expense is covered under one type of Covered Medical expense, it cannot be covered under any other type.

Payment Percentage

The Payment Percentage applies after any copay amounts.

Hospital Expenses

Emergency Room Treatment	
Emergency Care	100% after a $ 35* copay per visit

* These amounts are waived if a person becomes confined in a hospital.

Other Inpatient Hospital Expenses	100% after a $100 copayment
Other Outpatient Surgical Hospital Expenses	100%

Physician Fee (Primary Physician and Specialist Fees)

Office Care	100% after a $ 10 copay
Routine Physical Exam Expenses	100% after a $ 10 copay
Routine Eye Exam Expenses	100% after a $ 10 copay
Routine Hearing Exam Expenses	100% after a $ 10 copay
Other Physician Services	100%
Covered Medical Expenses incurred in connection with a mammogram	100%
Covered Medical Expenses incurred in connection with a Prostate Specific Antigen Test	100%

Other Covered Medical Expenses	
Convalescent Facility Expenses	100%
Home Health Care Expenses	100%
Skilled Nursing Care Expenses	100%
Hospice Care Expenses	
Inpatient Care	100%
Outpatient Care	100%
All Other Covered Medical Expenses for which a Payment Percentage is not otherwise shown	100%

Payment Percentage and Special Maximums

National Medical Excellence Travel and Lodging Expenses	100%

Alcoholism Drug Abuse, and Mental Disorders Expenses	
Inpatient Treatment	100%
Outpatient Treatment	100% for the first 5 visits, 100% after $10 copay for any other visits in the same calendar year
Alcoholism and Drug Abuse	
Special Inpatient Calendar Year Maximum Days	60
Maximum Visits	60
Mental Disorders	
Special Inpatient Calendar Year Maximum Days	30
Maximum Visits	20

Payment Limits

These limits apply to Covered Medical Expenses except expenses applied against copay amounts.

Payment Limit which Applies to Prescription Drug Expenses for a Person

When a person's Prescription Drug Expenses for which no benefits are paid because the Payment Percentage has reached $ 1,500 in a calendar year, benefits will be payable at 100% for all of his or her Prescription Drug Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Payment Limit which Applies to Prescription Drug Expenses for a Family

When a family's Prescription Drug Expenses for which no benefits are paid because the Payment Percentage has reached $ 3,000 in a calendar year, benefits will be payable at 100% for all their Prescription Drug Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Benefit Maximums

(Read the coverage section in your Booklet for a complete description of the benefits available.)

Short-Term Rehabilitation	
Maximum Days	90 per calendar year
National Medical Excellence	
Lodging Expenses Maximum	$ 50
Travel and Lodging Maximum	$ 10,000
Private Room Limit	The institution's semiprivate rate.

Lifetime Maximum Benefit: There is no Lifetime Maximum Benefit (overall limit) that applies to the Special Comprehensive Medical benefits described in the Booklet. The only maximum benefit limits are those specifically mentioned in your Booklet.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement, such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer. Any increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

KEEP THIS SUMMARY OF COVERAGE WITH YOUR BOOKLET

Additional Information Provided by Fairfax County Public Schools

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on the back of your ID card.